WYOMING MENTAL HEALTH DIVISION
CHILDREN'S MENTAL HEALTH WAIVER
Psychotropic Medication Consent Form

This form should be completed for any new medications prescribed during the time the child/youth is receiving waiver services.

Name: _____

Medication Prescribed (name/dose/frequency): _____

Name of Prescribing Clinician: _____

Start Date: _____ Review Schedule: _____

To be Reviewed and Signed by Parent or Legally Authorized Representative

I have had the opportunity to discuss medication concerns and ask questions of the prescribing clinician.

I understand there may be unknown risks for the medication being prescribed.

I understand that I may withdraw voluntary consent for this medication at any time. If abrupt discontinuation could potentially result in adverse effects, I understand that the medication will be withdrawn as quickly as clinically appropriate.

I understand that information about this medication will be shared with appropriate providers in the event of an inpatient admission, for the purposes of continuity of care.

☐ I consent to use of the above named medication.

☐ I do not consent to use of the above named medication.

Name of Parent/Legally Authorized Representative: _____

Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Attorney ☐ Other:_____

_____ _____
Signature of Parent/Legally Authorized Representative Date

_____ _____
Signature of Medication Prescriber Date

This section to be completed only if verbal consent is sought:

☐ Verbal consent was obtained ☐ Verbal consent was refused Date: _____

From: _____

Reason: _____

Request for written consent sent: _____

_____ _____
Family Care Coordinator Date

_____ _____
Witness Date

Discontinuation Date: _____ **Documented by:** _____

Form #: FCC-6
Implementation Date: 7/1/06 Revision Date: 9/1/07